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Gender Dysphoria and the Role of Occupational Therapy

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This evidence project, submitted by

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Key words: gender dysphoria, occupational therapy, transgender

Abstract

Prompted by Kristin Brubaker, a licensed pediatric occupational therapist who works at the Center for Therapeutic Intervention (CTI) in Gig Harbor, WA, the researchers set out to answer the following question: "What evidence supports the use of occupational therapy (OT) interventions in improving the psychosocial health of children and youth between the ages of 0 to 25 experiencing gender dysphoria (GD)?" After reading and evaluating 29 articles from qualitative and quantitative research, systematic reviews, and additional evidence, the researchers concluded that occupational therapists can assist this population by affirming the experience of GD, encouraging exploration of gender identity, providing a safe and supportive environment, maximizing strengths and resources, reflecting upon long-term consequences of various treatment approaches, facilitating social transition into preferred gender roles, and preventing loss of engagement in meaningful occupations. After summarizing these findings, the researchers conducted an in-service presentation at CTI regarding GD and the role of OT. In order to assess effectiveness, the researchers administered three surveys to monitor the clinicians' knowledge, confidence, and implementation of the aforementioned practice recommendations. Future continuations of this project could focus on compiling additional evidence to determine what constitutes effective parent/caregiver education for children with GD, and examining occupational deprivation within this population.

Executive Summary

In the spring of 2016, Kristin Brubaker recognized that the proportion of pediatric clients presenting with GD at CTI was growing. This piqued her interest in best practice techniques for transgender clients and she approached the School of Occupational Therapy at the University of Puget Sound to discuss the possibility of researching this topic. The researchers employed the following search terms during the evidence collection process: "gender dysphoria," "gender identity disorder," "children," "adolescents," "treatment," and "occupational therapy." The Archives of Sexuality and Gender (ASG), the Cumulative Index of Nursing and Allied Health Literature (CINAHL), the Education Resources Information Center (ERIC), the Primo database, and the University of Puget Sound's Sound Ideas were used as search databases. A targeted Google search for information regarding the Seattle Children's Gender Clinic was used as well as reference tracking from relevant articles. The most fruitful searches came from CINAHL, where the researchers accrued 14 of the total 29 articles.

The researchers discovered that OT practitioners can play a vital role in supporting transgender clients. However, there are currently no OT-specific, published guidelines regarding this clientele. As such, the process of providing interventions for this population will necessitate consistent reflection upon the long-term implications associated with differing approaches. In spite of this hurdle, the field of OT is well-aligned with other health professionals' formal recommendations for addressing patients with GD. Practice suggestions found in the literature reinforce core OT ideals such as client-centered care, validation of clients' concerns, and client advocacy.

Best practice techniques in caring for clients with GD include providing a supportive and safe environment in which clients can disclose their feelings without fear or repercussion. Before working with individuals experiencing GD, providers should be aware of their preconceived notions and biases related to this population. It is not suggested that practitioners deny the existence of GD but, instead, encourage the exploration of gender identity while protecting against negative reactions from others. In addition, it is important to consider the client's developmental trajectory. Current research does not always recommend that young children make the complete social transition to a preferred gender

before the early stages of puberty due to the low rates of GD persistence into adolescence. However, in the case of a social transition, occupational therapists can assist the client in learning and adjusting to new roles associated with their preferred gender.

Due to the high incidence of bullying experienced by children with GD, areas of potential program development include advocating for general awareness of the gender-variant experience, encouraging peer support, and promoting anti-bullying campaigns. Practitioners may work with adolescents to assess safety at school, rehearse scripts to counter questions or bullying, and facilitate the coming out and/or transitioning process with involved parties (e.g., teachers, classmates, and community members). In addition, healthcare clinics can adopt more inclusive practice techniques by modifying intake forms, inquiring about preferred names and pronouns, and documenting these preferences. Furthermore, practitioners may need to refer clients out for additional treatment to address coexisting mental health concerns and/or provide information and recommendations for peer support groups.

After summarizing these findings and implications, the researchers conducted an in-service presentation to four pediatric OT practitioners at CTI. The in-service was approximately 40 minutes in length and ended with an additional 10-minute question and answer session. The researchers also distributed three different surveys: a pre-presentation survey, a post-presentation survey, and a follow-up survey (see Appendices A, B, and C) to their audience to collect data regarding knowledge of GD, confidence in discussing GD, and implementation of findings. Overall, the researchers discovered that the practitioners felt the information presented in the in-service was clear, concise, useful, relevant to OT, and feasible to incorporate into practice. The practitioners' knowledge and confidence regarding GD increased as a direct result of the in-service presentation, thereby accomplishing one of the researchers' primary goals.

Focused Question:

What evidence supports the use of occupational therapy (OT) interventions in improving the psychosocial health of children and youth between the ages of 0 to 25 experiencing gender dysphoria (GD)*?

Collaborating Occupational Therapy Practitioner:

Kristin Brubaker, OTR/L

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Chair:

Kirsten Wilbur, Ed.D, OTR/L

Course Mentor:

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Date Review Completed:

January 26, 2017

***Additional Information:**

Within the literature, varying definitions of 'gender dysphoria' exist. For the purposes of this review, the researchers utilized the following definition provided by the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders: "A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration" (American Psychiatric Association, 2013).

Clinical Scenario:

Kristin Brubaker was interested in gaining a more comprehensive overview of effective treatments for clients with GD as these issues were currently not being addressed within her treatment sessions. She expected an increase in prevalence of this underserved population in OT practices and therefore welcomed any evidence of effective supplementary interventions.

Review Process

Procedures for the Selection and Appraisal of Articles

Inclusion Criteria:

The researchers used articles from the following disciplines: education, nursing, OT, physical therapy, physiotherapy, psychiatry, psychology, pediatrics, and social work. Articles with participants between the ages of 0 to 25 and interventions focused on addressing the accompanying sequelae of GD were included.

Exclusion Criteria:

Per Kristin Brubaker's request, articles published prior to 2000 were excluded. Additional articles were excluded if they included interventions that fell exclusively outside the scope of OT practice, the participants' GD was not the primary focus, or if they were previously referenced in literature reviews or meta-analyses that appeared in the critical appraisal of topic (CAT).

Search Strategy

Categories	Key Search Terms
Patient/Client Population	Children Adolescents Gender dysphoria Gender identity disorder
Intervention (Assessment)	Treatment Occupational therapy
Comparison	N/A
Outcomes	None, due to narrow search parameters

Databases and Sites Searched
Archives of Sexuality and Gender
Cumulative Index of Nursing and Allied Health Literature
Education Resources Information Center
Google search for Seattle Children's Gender Clinic
Primo
University of Puget Sound's Sound Ideas

Quality Control/Peer Review Process

The researchers began with a preliminary search in the Primo database to determine the breadth of published, peer-reviewed literature on the topic. At that point, the researchers determined that the search terms should be expanded to the farthest extent possible, due to the apparent dearth of applicable material. From that search, two articles were reviewed and analyzed. They also sought advice from faculty members and their appointed library liaison to develop more effective search strategies.

The researchers collected additional data via the Primo, ERIC, CINAHL, and ASG databases. They discovered another four articles in the Primo database, but were unable to complete an exhaustive

search due to a course deadline. The researchers chose not to pursue any additional evidence from this particular search, as other findings were determined to be repetitive. All 18 articles from ERIC were excluded; four were published prior to 2000, seven were outside of the scope of OT, and seven focused on other diagnoses or topics. All of the results from the ASG searches were also excluded, as three articles fell outside of the scope of OT and one was irrelevant.

Searches in the CINAHL database were more successful, as they produced a total of 14 articles that fulfilled all previously stated inclusion/exclusion criteria. This search was conducted on two separate occasions, as, on the first round, the researchers mistakenly excluded articles that required interlibrary loans or supplementary searches. In sum, 106 articles were found (one new article was published to the database since the first search on October 17, 2016), but 92 were excluded for the following reasons: one article was listed twice in the database, four focused on adults, five did not focus on GD as a primary diagnosis, six were published prior to 2000, seven pertained to saturated topics, eight were unrelated to the topic, and 61 were outside the scope of OT. Another CINAHL search was conducted on January 24, 2017. Two new articles had been published to the database since the previous CINAHL search. One article focused on adults and one article was an obituary; therefore, neither were added to the CAT table.

Results of Search

Table 1. Search Strategy of databases.

Total Selected for Review	Articles Excluded	Initial Hits	Database	Date	Search Terms
2	*	293	Primo	09/20/2016	Gender dysphoria in children and adolescents
4	*	293	Primo	10/06/2016	Gender dysphoria in children and adolescents
0	15	15	ERIC	10/08/2016	Gender dysphoria
9	96	105	CINAHL	10/17/2016	Gender dysphoria
0	0	0	ERIC	10/21/2016	Occupational therapy and gender dysphoria
0	0	0	ERIC	10/21/2016	Occupational therapy and gender identity disorder
0	3	3	ERIC	10/21/2016	Gender dysphoria and treatment
5	101	106	CINAHL	11/10/2016	Gender dysphoria
0	0	0	ASG	11/13/2016	Gender dysphoria and children
0	4	4	ASG	11/13/2016	Gender dysphoria
0	0	0	Sound Ideas (UPS)	11/13/2016	Gender dysphoria
0	108	108	CINAHL	1/24/17	Gender dysphoria
Total number of articles used in review from database searches = 20					

Note. * = Search not completed due to saturation

Table 2. Articles from citation tracking.

Total Selected for Review	Articles Excluded	Initial Hits	Database	Date	Article
Total number of articles used in review from citation tracking = 0					

Table 3. Articles from reference tracking.

Total Selected for Review	Articles Excluded	Articles Referenced	Date	Article
3	2	5	10/22/2016	Schuster et al., (2016)
5	26	31	10/24/2016	Cousino et al., (2014)
Total number of articles used in review from reference tracking = 8				

Total number of articles used in review from database searches = 20
Total number of articles used in review from Google search = 1
Total number of articles used in review from citation tracking = 0
Total number of articles used in review from reference tracking = 8
Total number of articles used in review from UPS Master's Thesis = 0
Total number of articles used in CAT = 29

Summary of Study Designs of Articles Selected for the CAT Table

Number of Articles Selected	Study Design/Methodology of Selected Articles	Pyramid Side
0	0 Meta-Analyses of Experimental Trials 0 Individual Blinded Randomized Controlled Trials 0 Controlled Clinical Trials 0 Single Subject Studies	Experimental
0	0 Meta-Analyses of Related Outcome Studies 0 Individual Quasi-Experimental Studies 0 Case-Control Studies 0 One Group Pre-Post Studies	Outcome
3	1 Meta-Syntheses of Related Qualitative Studies _Group Qualitative Studies w/ more Rigor ___brief vs prolonged engagement with informants ___triangulation of data (multiple sources) ___interpretation (peer & member-checking) ___a posteriori (exploratory) vs a priori (confirmatory) interpretive scheme 2 Group Qualitative Studies w/ less Rigor _ Qualitative Study on a Single Person	Qualitative
11	2 Systematic Reviews of Related Descriptive Studies _ Association, Correlational Studies	Descriptive

	2 Multiple Case Studies (Series), Normative Studies _ Individual Case Studies 7 Survey	
15	4 Expert opinion 1 Narrative literature review 2 Literature review 2 Standards of practice/practice guidelines 1 Program overview 1 Service guide 1 Informative article 1 Letter to the editor 1 Task force report 1 Policy statement	Additional Literature
TOTAL= 29	Comments: American Occupational Therapy Association's Levels of Evidence I- 2 II- 0 III- 1 IV- 9 V- 11 Number does not match total number of articles because not all articles could be classified according to this hierarchy.	

Summary of Key Findings

Summary of Experimental Studies

N/A

Summary of Outcome Studies

N/A

Summary of Qualitative Studies

Individuals with GD experience barriers to healthcare including limited access to providers with relevant gender-affirming experience and sensitivity. Even healthcare professionals who are willing to support and advocate for children experiencing GD report misunderstandings of the nature

of sexual and gender identity. Currently, there is no consensus on an optimal treatment approach to provide assistance to individuals with GD (Gridley et al., 2016).

Summary of Descriptive Studies

The transgender community is currently underserved. This problem is exacerbated by the fact that many people with GD face threats to their fundamental biological needs (Reisner et al., 2016). Furthermore, this population commonly experiences the following challenges: stigmatization, anxiety, depression, and self-harm. One study found that natal males with GD experience more internalizing behaviors than natal females with GD. Interestingly, this study referenced previous literature which identified natal females without GD as experiencing greater frequency of internalizing behaviors (Skagerberg, Davidson, & Carmichael, 2013). Additional research shows that many children with GD report first experiencing gender-variant feelings in early childhood and often present with significant psychiatric histories. While anxiety is a common comorbidity in this population, diagnosis of an anxiety disorder is not a risk factor for GD (Wallien, Swaab, & Cohen-Kettenis, 2007). Remarkably, despite the many traumatic experiences that individuals with GD often experience, one study has shown that they are significantly less likely than other clients to commit an act of aggression towards a therapist (Barker & Wylie, 2008).

The needs of children experiencing GD include knowledge of available services, contact with peers, freedom of gender expression, safety, usage of preferred names and pronouns, emotional validation, and acceptance by their families. The needs of parents raising children with GD include knowledge of available services, peer support, and access to research and educational resources (Riley, Sitharthan, Clemson, & Diamond, 2013). Erasmus, Bagga, and Harte (2015) evaluated patient satisfaction at a multidisciplinary GD clinic in Melbourne and discovered that 88% of patients surveyed were satisfied. In addition, the authors found a significant decrease in patients' distress from time of consultation to time of survey, which was about one month later. While the authors did not

provide a specific reason for this reduction, it is possible that once established with a GD clinic, patients begin to feel a reduction in their stress levels.

Summary of Additional Literature

There is evidence that the transgender population is growing. One theory is that this growth coincides with increased media portrayals of people with GD (Zucker, Bradley, Owen-Anderson, Kibblewhite, & Cantor, 2008). In order to decrease stigma, both education and awareness need to be increased and healthcare professionals should be prepared to advocate and educate on behalf of individuals with GD. At a minimum, healthcare providers need a baseline understanding of the nature of GD and associated issues. The healthcare field is in the midst of a transition from a disease-based to an identity-based model of transgender health, in which the focus of modification is social stigma and the environment, not the individual.

The best treatment approach for children with GD remains controversial as there are no current means of predicting whether gender variance in childhood will persist through adulthood. The majority of practice suggestions differ by age group of clients. Some approaches suggest that treatment for children under 12 should not target GD via medical interventions, but should focus on the accompanying emotional, behavioral, or familial problems. For children over 12 years old, it is commonly recommended that existing psychosocial treatments should continue and consideration and discussion of hormonal and medical interventions may become more appropriate. Research indicates that children with GD benefit from psychotherapy, counseling aimed at securing a positive self-image and dealing with negative reactions, and practitioners' affirmations of preferred gender. Additionally, using a positive development approach emphasizing the individual's competencies and social connectedness may contribute to greater resilience and healthier developmental trajectories (Holman & Goldberg, 2006). Regardless of treatment approach, including the family is essential to ensuring the best possible outcomes for the child or adolescent.

Implications for Consumers

The reviewed client population was limited to individuals experiencing GD between the ages of 0 and 25 and their families or caregivers. However, all individuals experiencing any degree of GD are potential consumers who may benefit from this research endeavor. Clients can advocate for themselves by being aware of best practice guidelines related to gender-affirming care in order to determine any healthcare disparities and begin to take appropriate actions. Specifically, clients may advocate for themselves by being explicit in their requests for healthcare providers to utilize preferred names and pronouns.

Clients should seek service providers who do not attempt to invalidate their feelings of dysphoria or deter them from exploring their gender identity, as external pressure to adhere to their natal sex is associated with negative psychosocial outcomes. Based on this review, there is a demonstrated need for additional research in order to inform and guide gender-affirming practice.

Implications for Practitioners

The research suggests that all healthcare providers should be informed and prepared to provide best practice for individuals experiencing GD. Although there are currently no American Occupational Therapy Association Practice Guidelines for children and youth with GD, the profession of OT is well suited to address patients with GD due to the field's core values and scope of practice. In addition, it is important to prevent loss of engagement in meaningful occupations while transitioning from one gender to another, and occupational therapists can be valuable assets during these transitions. Occupational therapists can also help those individuals who may need assistance adjusting to new social roles and reentering the community in their preferred gender.

Best practice techniques in caring for individuals with GD include providing a supportive and safe environment in which they can disclose their feelings without fear or repercussion. In fact, a nationwide survey revealed that 28% of people with GD have delayed healthcare treatment due to

fear of discrimination (Grant et al., 2011). Before working with any clients experiencing GD, providers should be aware of their pre-conceived notions and biases related to this population. A study by Ettner, White, Brown, and Shah (2006) suggested that practitioners who are knowledgeable about various aspects of GD may reduce their clients' morbidity and encourage a strong therapeutic alliance.

During treatment, it is important to consider developmental trajectory; it is not always recommended that young children make the complete social transition to their preferred gender before the early stages of puberty due to the low rates of GD persistence into adolescence. However, it is not suggested that practitioners deny the existence of GD, but instead encourage the exploration of gender identity while protecting against negative reactions from others. It is recommended that practitioners focus on maximizing strengths and resources while acknowledging and minimizing risky behaviors of clients. Due to the high incidence of bullying experienced by children with GD, areas of potential program development include advocating for general awareness of the gender-variant experience, encouraging peer support, and promoting anti-bullying campaigns. Additionally, practitioners may work with adolescents to assess safety at school, rehearse scripts to counter questions or bullying, and/or facilitate the coming out or transitioning process with involved parties (e.g., teachers, classmates, community members).

Healthcare clinics can adopt more inclusive practice techniques by modifying intake forms, inquiring about preferred names and pronouns, and documenting these preferences. Current research also describes a need to improve the quality, breadth, and accessibility of medical information related to GD in healthcare clinics and online (Erasmus et al., 2015). Furthermore, practitioners may need to refer clients out for additional treatment to address coexisting mental health concerns and they may simultaneously provide information and recommendations for peer support groups. Based on client reports, providers in the United States would benefit from incorporating treatment principles utilized in countries that are more experienced in collaborating with clients with GD.

Implications for Researchers

Due to the current shortage of empirical literature, further research is needed to determine optimal supports and interventions for individuals with GD. No single approach will work for every individual, but treatment guidelines for addressing the issue with children and adolescents remain an unfulfilled need for practitioners.

The ethical barriers in conducting experimental research with this population, specifically in withholding treatment from a control group, have thus far prevented higher level experimental research. Thus, current literature falls within the realms of qualitative studies, normative studies, and expert opinion articles. While these resources are valuable, many pertain to variables that fall outside of the scope of OT. For example, many studies focus on available medical interventions, but the conclusions from these articles are difficult to generalize to non-medical settings. Accordingly, there is simply not yet sufficient data to formulate solid recommendations of best practice principles within the scope of OT.

Universal agreement among researchers in regards to terminology used to describe the population of individuals with GD will aid in the consolidation of practice-informing knowledge and facilitate the development of therapeutic interventions to best assist clients experiencing GD. Additionally, new research should take a more phenomenological approach in order to provide specific recommendations regarding which traditional practice principles should be modified or avoided altogether while assisting this population. Individuals with GD could provide crucial information regarding techniques they have found to be either detrimental or beneficial to their overall psychosocial health.

Bottom Line for Occupational Therapy Practice/ Recommendations for Best Practice

Based on the research reviewed thus far, occupational therapists must take into account the complex presentation of associated sequelae that often accompany the experience of GD. Many factors influence the trajectory of GD, and it should not be regarded as a singular issue. Despite the lack of established guidelines, it is agreed that the best way to assist children with GD is to work in a collaborative way that facilitates exploration of gender identity rather than inhibits or invalidates their experience. Additionally, OT practitioners should be aware that children with GD are more likely than their peers without GD to experience internalizing behaviors such as depression and anxiety. It is also important to note that their parents may not be aware of such behaviors (Skagerberg, Davidson, & Carmichael, 2013). Thus, it is imperative that practitioners are cognizant of the child's mental health status to ensure they are providing appropriate care.

In order to improve practice on this topic, it is important for practitioners to engage in conversation about their experiences supporting this population. The sharing of knowledge will add to the growing body of literature informing practice with this underserved population.

Table Summarizing the *QUANTITATIVE* Evidence

Author, Year, Journal Abbreviation	**Study Objectives**	**Study Design/ Level of Evidence**	**Participants: Sample Size, Inclusion and Exclusion Criteria**	**Interventions & Outcome Measures**	**Summary of Results**	**Study Limitations**
Holt, Skagerberg, & Dunsford, (2016), *CCPP*	Obtain overview of youth w/ GD. Variables considered: age at 1st GD feeling, sexual orientation, & challenges faced.	Normative, AOTA: IV, Pyramid: D3	*N* = 218 (n_f = 136.9), age range 5-17yo (M_{age} = 14yo). Inclusion: 0-18yo, new referrals to GIDS 1/1/12-12/21/12. Exclusion: children receiving ther because a parent had GD.	25 variables considered: gender, family & parental status, ASCs, anxiety. Referrals & chart notes reviewed by GIDS psychiatrist & psychologists.	1st GD feeling 0-6yo = 42.7%, 7-12yo = 34.9%, 13-18yo = 17.9%, no sig difference between genders, 10 participants chose to not answer this question. Preference of name other than birth name = 47.8%, sig different between genders ($p < 0.001$). Bullying (47%), depression (42%), & self-harm (39%) most common challenges.	Same demographics not reported in every chart--may have resulted in lower figures. Assumed behaviors not listed did not occur. Small sample in younger age grp. Only charts reviewed, authors did not clarify info w/ youth.
Erasmus, Bagga, & Harte (2015), *Australasian Psychiatry*	Determine pt satisfaction w/ svcs received at a multidisciplinary GD clinic in Melbourne.	Survey, AOTA: IV, Pyramid: D3	*N* = 127, pts in contact w/ clinician at GD clinic w/i 1 mo period. M_{age} = 34.12 yo (range 18-64). No other inclusion criteria, exclusion criteria: pts seen outside of 1 mo survey window.	Anonymous survey-27 questions, 7-point Likert satisfaction scale & open-ended questions re: pt exp & desired changes or additional svcs.	88% of pts satisfied w/ svcs received. Pts overall stress level decreased sig from 1st interaction w/ clinic to time of survey ($p < 0.001$). Pos themes from questions: being heard & not judged. Neg themes: wait times & lack of info in clinic prepared materials. Additional desired svcs: staff education & peer support grps.	Surveys only provided to pts w/i short timeframe. Study focused on one clinic, not all clinics have same policies & procedures. Pts may have been reserved in their responses for fear of jeopardizing their hc.

Davies et al., (2013), *SRT*	Measure pt satisfaction w/ current GIC svcs in the UK.	Survey, AOTA: IV, Pyramid: D3	*N* = 282, pts attending respective GICs April-May 2011. Other exclusion or inclusion criteria not explicitly stated.	Anonymous survey-19 questions, 5-point Likert scale of satisfaction, & open-ended questions re: past exp & desired changes.	Pts reported more pos than neg comments, they received life changing info, felt accepted. Neg comments mainly re: admin issues rather than care. Suggested svc changes: desire for grp/family or indiv ther, employment advice, mentors, home visits, change of name advice. 94% would recommend svc.	Methodological rigor sacrificed in favor of attempts to not alienate clients. Short length of study time (1 mo) ltd opportunity for pts to participate.
Skagerberg, Davidson, & Carmichael, (2013), *IJT*	Determine number of adolescents at GIDS w/ internalizing or externalizing behaviors & presence of behavioral differences based on gender.	Survey, AOTA: IV, Pyramid: D3	*N* = 141 (n_f = 84), age range 12-18yo (M_{age} = 15.13yo). Inclusion: newly referred to GIDS (w/i first 6 mo of attending clinic), dx of GID. No exclusion criteria specifically stated.	Youth Self Report form: used for 11-18 yo, 118 problem behavior questions categorized into either internalizing or externalizing, 3 point scale. Forms given to pt by provider, once completed either given back to provider or mailed back.	Adolescents w/ GD present w/ internalizing behaviors rather than externalizing. 60% natal males presented w/ clinically sig internalizing behaviors when compared to 44% of natal females. This finding is opposite from what has been observed in non-GD populations. Statistically sig relationship between internalizing & externalizing behaviors w/i each gender & overall.	Only newly referred pts w/ dx of GID were included in study, left out those who had started receiving care earlier. Those pts who hadn't yet been dx'd not included. Only one clinic included, no control grp used, & no mention of whether or not form was anonymous.

Spack et al., (2012), *Pediatrics*	Examine clinical & demographic data of pts w/ GID.	Normative, AOTA: IV, Pyramid: D3	*N* = 97 pts (n_f = 54). M_{age} = 14.8yo. Inclusion: under 21, hx of cross-gender behaviors, in or past puberty, in MH counseling, supportive parents, & letter of referral from MHP. Exclusion: not stated.	Pts received psychotherapy tx. W/ intro of formal gender clinic, clientele increased fourfold, indicating profound need for med intervention in tx of GID.	44.3% of participants presented w/ sig psychiatric hx. 57.7% began a med intervention w/i 1 wk of initial visit. M_{age} at start of tx was 15.6yo. 60% of pts attracted to members of the same sex (as natal sex), 18.2% attracted to opposite sex, 12.7% unsure, & 9.1% to both sexes.	Ltd generalizability, because only examined 1 grp in a specific region & pts w/o supportive parents were excluded. Some variables (e.g., parents' marital status & pt's sexual orientation) not reported for all pts & may have skewed findings.
Grant et al., (2011)	Determine the extent of types of discrimination experienced by people w/ GD.	Survey, AOTA: IV, Pyramid: D3	*N* = 6,450 TG & gender nonconforming ppl from all US states & territories	Participants completed a survey re: discrimination in spheres of education, employment, health, family life, housing, public accommodations & incarceration.	Respondents who present differently than their preferred gender ("visual non-conformers") are most at risk for discrimination. Racial biases compound already present discrimination. 28% postponed med care due to fear of discrimination, 50% reported having to teach med provider about TG care, over 25% abused drugs or alcohol to cope w/ mistreatment, 19% were denied care, & 57% exp'd family rejection.	Structured survey questions ltd variety of responses, restricted to ppl living in the US.

Wallien et al., (2007), *JAACAP*	Examine comorbidities in children w/ GID.	Normative, AOTA: IV, Pyramid: D3	*N* = 167, n_{GID} = parents of 120 Dutch pts at gender clinic (ages 4-11), n_{ADHD} = parents of 47 Dutch pts at ADHD clinic (ages 5-12). Exclusion for grp 1: no GID dx & IQ < 75. Other exclusion & inclusion criteria not explicitly stated.	All parents completed Dutch translation of DISC, a structured interview that assesses common disorders on DSM axis I.	52% of children w/ GID met criteria for another dx. 60% of children w/ ADHD met criteria for a separate dx. Difference in rates between 2 grps not statistically sig. Internalizing disorders more common than externalizing disorders in children w/ GID. Anxiety disorders were most common among children w/ GID (31% presented w/ the diagnostic criteria). Children w/ GID are at risk for other psychosocial disorders, but anxiety disorder is not a risk factor for GID.	Much smaller sample size for ADHD grp, data ltd to parental perspective, did not account for PDDs, only 2 clinics studied, only Dutch children studied.
Ettner et al., (2006), *IJT*	Compare the prevalence & severity of aggression infliction upon therapists by both TG & non-TG clients.	Survey, AOTA: IV, Pyramid: D3	*N* = 114 therapists, n_f = 60%, n_m = 26%, n_{TG} = 14%. Respondents included psychologists, psychiatrists, therapists, social workers, family & sex therapists, nurses, & counselors from various settings & countries.	Respondents completed 34-item questionnaires re: client aggression.	TG clients sig less aggressive towards therapists than non-TG clients. MTF clients sig more aggressive than FTM clients. Possible reasons for lower aggression levels among TG clients: relief from stigma while working w/ therapists, clients recognize ther may reduce psychosocial risks, clients have good understanding of their GD which ↑ chances for pos therapeutic alliance, or clients refrain from emotionally-charged topics.	Higher proportion of American and Canadian respondents, 44% of professionals did not respond to questionnaire, study ltd to incidence & type of aggression rather than motivation.

Abbreviation List: & = and; ↑ = increases; ADHD = attention deficit hyperactivity disorder; admin = administrative; AOTA = American Occupational Therapy Association; ASCs = Autism spectrum conditions; *CCPP*: *Clinical Child Psychology and Psychiatry*; DISC = Diagnostic Interview Schedule for Children - Parent Version; DSM = Diagnostic and Statistical Manual; dx(‘d) = diagnosis (diagnosed); exp(‘d) = experience(d); FTM = female-to-male; GD = gender dysphoria; GIC = gender identity clinic; GID = gender identity disorder; GIDS = Gender Identity Development Service; grp(s) = group(s); hc = healthcare; hx = history; *IJT* = *International Journal of Transgenderism*; indiv = individual(s); info = information; intro = introduction; IQ = intelligence quotient; *JAACAP* = *Journal of the American Academy of Child & Adolescent Psychiatry*; ltd = limited; M_{age} = mean age; med = medical; MH = mental health; MHP = mental health professional; mo = month; MTF = male-to-female; *N* = population size; n_{ADHD} = sample size from ADHD clinic; neg = negative; n_f = sample size (females); n_{GID} = sample size from gender clinic; n_m = sample size (males); n_{TG} = sample size (transgender); PDD = pervasive developmental disorder; pos = positive; ppl = people; pt(s) = patient(s); re: = regarding; sig = significant(ly); *SRT* = *Sexual and Relationship Therapy*; svc(s) = service; TG = transgender; ther = therapy; tx = treatment; UK = United Kingdom; US = United States; w/ = with; w/i = within; wk = week; w/o = without; yo = year(s) old.

Note. The report by Grant et al., (2011) did not appear in a journal.

Table Summarizing the *Meta-Analyses/Meta-Syntheses/Systematic Review* Evidence

Author, Year, Journal Abbreviation	**Study Objectives**	**Study Design/Level of Evidence**	**Number of Papers Included, Inclusion and Exclusion Criteria**	**Intervention & Outcome measures**	**Summary of Results**	**Study Limitations**
Reisner, et al., (2016), *The Lancet*	To highlight the contextual factors that may exacerbate the health risks or facilitate the resiliencies of TG indiv.	Systematic rvw, AOTA: I, Pyramid: D1	116 studies; inclusion: on-topic, quant study, published 2008-2014, in English, French, or Spanish; exclusion: published pre-2008, appeared online ahead of print, qual study, re: intersex indiv, re: neuroanatomy or neuropsychology, re: gender reassignment outcomes, gender identities not explicitly stated.	Effective intervention strategies w/i the TG population incorporate gender-affirmation svcs, evidence-based hc delivery systems, & collaboration w/ local TG communities. These strategies help to mitigate health-related vulnerabilities (like anxiety, depression, substance abuse, etc.) observed w/i this population.	Global disease & health burden present in TG population, & these issues remain understudied, underfunded, & underrepresented. General health characteristics of TG indiv researched least often, & need to meet biological needs may inhibit ability to address perceived health risks.	Difficult to capture all evidence due to variations in search terms. Possibility of inflated data due to method of reporting data at data-points level. Did not incorporate valuable info from other sources (qual studies, non-peer reviewed articles, etc.).

Byne et al., (2012), *ASB*	Examine existing lit on tx of GID at various ages, assess quality of tx evidence, & to formulate an opinion on the necessity of APA tx recs.	Meta-analysis, AOTA: I, Pyramid: Q1/D1 No RCT for any grp. Children: expert opinion, LT follow ups w/o specific intervention, qual rvws. Adolescents: indiv case report, follow up w/ control grps w/o random assignment, & rvws. Adults: case reports/series, & rvw articles. DSD: LT follow ups, rvws.	Number of included papers not stated. Inclusion: indiv w/ GID, GV or GD & somatic DSDs (GIDNOS). Adolescent= 12-18yo Adults = older than 18yo, seeking MH svc for reasons related to GV, some of whom meet criteria for GID. Exclusion: not explicitly stated.	Children: Psychotherapeutic tx, behavior modification, parent & peer-relations focused tx, parent/child therapeutic grps, increase self-acceptance & resilience. Adolescents: psychotherapy, psychoeducation of child, family & institutions, safety assessment of environments. Adults: no universal agreement re: tx goals except improving sense of wellbeing & overall functioning. Outcomes: "subjective improvement" psychological adjustment & well-being, lack of GID in adulthood.	Previous lit adequate for development of consensus-based tx rec for all subgrps. There is no consensus on best tx for GID. OT rec: psychoeducation & counseling of child/family re: tx options & potential discrimination, assess difficulties in caregiver-child relationship, provide assistance navigating real life issues arising w/ the changing of gender/ non-gender conforming exp.	Ltd range of evidence levels exist in the lit for rvw. In general, ltd amount of info on topic available. LT follow up studies for DSD have low sample size, heterogeneity & inadequately sized control grps.

Abbreviation List: & = and; AOTA = American Occupational Therapy Association; APA = American Psychiatric Association; *ASB* = *Archive of Sexual Behavior*; DSD = disorder of sex development; exp = experience; GD = gender dysphoria; GID = gender identity disorder; GIDNOS = gender identity disorder not otherwise specified; grp(s) = group(s); GV = gender variance; hc = healthcare; indiv = individual(s); info = information; ltd = limited; lit = literature; LT = long term; MH = mental health; OT = occupational therapy; qual = qualitative; quant = quantitative; RCT = randomized controlled trial; re: = regarding; rec(s) = recommendation(s); rvw = review; svc(s) = service(s); TG = transgender; tx = treatment, w/ = with; w/i = within; w/o = without; yo = year(s) old.

Note. Byne et al., (2012) used their own levels of evidence hierarchy separate from AOTA/pyramid, thus they are described as in report.

Table Summarizing the *QUALITATIVE Evidence*

Author, Year, Journal Abbreviation	**Study Objectives**	**Study Design/ Level of Evidence**	**Participants: Sample Size, Description Inclusion and Exclusion Criteria**	**Methods for Enhancing Rigor**	**Themes and Results**	**Study Limitations**
Gridley et al., (2016), *JAH*	ID barriers TG youth & caregivers face accessing hc. Recs made for improving access. Barriers demonstrate need for development of gender clinics.	Phenomenological, AOTA: N/A, Pyramid: Q3	TG youth 14-22yo (*N* = 15, caregivers (*N* = 50). Youth from Seattle area clinics, SCH & blog, & support grp listserv. Inclusion: 14-22yo, any stage of gender transition, GD	Analysis started before end of data collection, participant recruitment closed w/ theme saturation, & triangulation of main themes.	Barriers: lack of provider exp w/ gender-affirming care & consistent protocols, improper use of preferred names/pronouns. Recs: require provider training of gender-affirming care & cultural sensitivity, estab care protocols, inquire & use preferred names/pronouns. Gender clinics may improve hc exps of youth w/ GD.	Convenience sample. Participation required caregiver consent-youth w/o family support not considered. Most participants from WA, white, & w/ higher edu levels-exps & barriers not same for other racial or SES grps. Different questions asked in ⅔ sampling methods-may have missed pertinent responses.
de Jong, (2015), *CASWJ*	Explore perceptions, attitudes, practices of school social workers working w/ children w/ GV.	Phenomenological, AOTA: N/A, Pyramid: Q3	Public school district social workers in NE US, *N* = 14 females, 35-44yo, recruited at school-community meetings, school district websites & snowball sampling. Exclusion criteria not stated.	Transcribed interviews, analyzed using interpretative phenomenological analysis w/ both deductive & inductive processes. Coded according to	Social workers willing to support & advocate for GV students, but misunderstandings about differences between gender & sexual identity. Role of OT: Being a safe place for children to disclose feelings of dysphoria. Providing "scripts" to counter questions/bullying. Assess safety at school. Facilitate	Self-reported data, potential for bias in data analysis, one geographic area. Participants were all 35-44yo females.

				sensitizing concepts.	coming out or transitioning by involving team members/classmates.	
Riley et al., (2013), *Sex Education.*	Establish needs of GV children, parents & TG adults & provide research based evidence to enhance programs, training & policies.	Survey, AOTA: IV, Pyramid: D3	Parents of GV children, TG adults who experienced GV as a child & clinical professionals. International participants sought. *N* = 170. Excluded if didn't answer any open-ended survey questions or if GV was ID'd after age 12.	Ongoing analysis of responses by question, participant, grp, then summarized. Used manual method to record trail of thinking via color coding & access to previous steps & saved versions of analysis.	Needs of children: info, peer contact, personal gender expression, safety, to be heard & accepted by parents. Parental needs: info (stories from others, research, peer support), education resources. H-A-P-P-I-N-E-S-S: to be Heard, Accepted, Professional access & support, Peer contact, current Info, Not bullied/blamed/punished/ discriminated, freedom of Expression, feel Safe, have Support.	Study did not question children experiencing GD. Self-reported surveys only available to computer users & restricted participants' ability to express self thru text, & only in English. No ability to ask follow-up questions. No lesbian or gay indiv were questioned even though they also often exp GV. Parents who did not accept GV in their child did not participate.

Barker & Wylie, (2008), *IJT*	Explore the pros & cons of the RLE stage of assessing GD of a regional gender clinic.	Survey, AOTA: IV, Pyramid: D3	*N* = 19 MTF TG clients. Criteria of RLE req of clinic: attended clinic for 18 mos, attended speech ther, attended support grp, official name change, docs mod to reflect name change, F-T or P-T job status, 2 yrs of social interactions in new gender (w/ consistent dress), no sig MH probs or contraindications, over 21yo, surg & 2nd opinions acquired.	All participants were asked all questions, specific questions are explicitly stated in article, & responses separated into themes.	18 clients were living in new gender role F-T. Clients' criticisms for RLE req centered on these main themes: neg effects on client-therapist relationship, overly rigid specs of RLE req, reductions in length of RLE req. However, majority felt RLE req was important, useful, & easy to follow. 5 reported problems living in new gender role as part of RLE req.	Limited geographical area, small sample size, similar exps w/ RLE req due to attending same clinic, study not representative of entire population as study only includes MTF clients, & 17 clients reported that they would live in role regardless of RLE req.

Abbreviation List: & = and; AOTA = American Occupational Therapy Association; *CASWJ = Child and Adolescent Social Work Journal*; doc(s) = document(s); edu = education; estab = establish; exp(s) = experience(s); F-T= full-time; GD = gender dysphoria; GI = gender identity; grp(s) = group(s); GV = gender variance; hc = healthcare; ID('d) = identify (identified); *IJT* = *International Journal of Transgenderism*; indiv = individual(s); info = information; *JAH* = *Journal of Adolescent Health*; MH = mental health; mod = modified, mo(s) = month(s); MTF = male to female; *N* = population size; N/A = not applicable; NE = Northeast; neg = negative; OT = occupational therapy; P-T = part-time; prob(s) = problem(s); rec(s) = recommendation(s); req = requirement; RLE = real life experience; SCH = Seattle Children's Hospital; SES = socioeconomic status; sig = significant; spec(s) = specifications; surg = surgical; TG = transgender; ther = therapy; thru = through; US = United States; WA = Washington state; w/ = with; w/o = without; yo = year(s) old; yr(s) = year(s).

Table Summarizing *Additional Literature Evidence*

Author, Year, Journal Abbrev-iation	**Qualifica-tions of Author**	**Type of Article**	**Referenc e To External Lit?**	**Purpose**	**Conclusions**	**Implications for Practice**	**Limitations**
Schuster, Reisner, & Onorato, (2016), *NEJM*	M.D./PhD, Sc.D., M.A. Affiliated w/ Harvard	Expert opinion, AOTA: V, Pyramid: N/A	Yes	Highlight need for holistic hc for TG population, due to high risks of psychosocial issues.	TG population is growing. Gender affirmation improves psychosocial health. Practitioners need to be well-prepared & well-informed to assist clients w/ GD.	OTs can assist by discussing risk factors, supporting clients & their families, adopting more inclusive intake forms, inquiring about preferred pronouns, & advocating for clients w/ GD.	Acknowledges steps need to be taken to protect TG community, but provides only generic info re: how to accomplish goals.
Australian Nursing & Midwifery Association, (2014), *ANMJ*	Not specified	Informative article, AOTA: N/A, Pyramid: N/A	No	Acknowledge psychosocial dangers associated w/ lack of med knowledge & tx of GD.	Australian LGBTI community forced to relocate when adequate svcs not avail. LGBTI population growing due to reduced stigma. More funding & resources needed.	Lack of acceptance leads to poor psychosocial outcomes (like suicide). Stigmatization should be diminished thru education & awareness of GV.	Does not provide the author's name or qualifications. Ltd to Australia.
Gregor, Davidson, & Hingley-Jones (2014), *CFSW*	MH advisor, clinical psychologist, & senior lecturer	Lit rvw, AOTA: V Pyramid: N/A	Yes	Provide social workers (& other hc providers) w/ overview of current lit, increase understanding, &	Parents of indiv w/ GD do not feel hc providers understand GD & associated exps. GD is complex & ltd research avail.	Hc providers need a baseline understanding of GD & should maintain an open mind when working w/ families of children w/ GD. Providers should be aware of their pre-conceived	No info provided on how lit was selected for rvw.

				quality of care for families of children w/ GD.		notions & biases related to this dx. Providers should not introduce bias into tx & should allow room for child & family to explore.	
Drescher, & Pula, (2014), *Hastings Center Report*	Not specified	Expert opinion, AOTA: V, Pyramid: N/A	Yes	Discuss ethics surrounding tx or non-tx of prepubertal children w/ GD or GV, as majority of GD diagnoses in children cease around puberty.	Best tx remains controversial. No means of predicting whether GD or GV will persist/desist. No evidence to determine if GD in adulthood is preventable. Children who transition once may later desist & transition again. Natal females more likely to persist. Tx & non-tx both carry risks.	Practitioners should be forthright w/ clients & families by stating that best tx pre-puberty will vary based upon indiv needs & preferences. They must provide support during a time of difficult & often painful decision-making. Clinicians should continuously reflect upon ethics involved w/ this clientele, as they await development of practice standards.	No conclusive recommendations. Acknowledges higher quality research needed, as most lit is opinion-based.
Cousino et al., (2014), *CPPP*	Medical professionals	Expert opinion, AOTA: V Pyramid: N/A	Yes	Discuss role of pediatric psychologist w/i multidisciplinary clinic for children w/ GD.	Psychologist works w/ parents struggling w/ responding to child's request to present as opp gender, works w/ family to understand potential outcomes & perform assessments.	Suggests an approach that is supportive & strength-based, encouraging family acceptance & affirmation of the child's GI, but there is a lack of evidence guiding tx.	Psychologist qualifications do not match the scope of practice of OT. Recommended tx approach not evidence-based.
Ahmad et al., (2013),	Psychiatrists, psycholo	Svc guide, AOTA: V, Pyramid:	Yes	Inform GPs & other hc providers what	Provide GPs w/ an outline of what must be considered when caring	Children may need time to decide how to proceed. During transition, indiv	Designed for NHS in UK. US has different hc

SRT	gists, endocrinologist, & svc manager	N/A		svcs need to be accessible & provided to ppl w/ GD. Covers many hc topics.	for indiv w/ GD. Key points: when to refer to GS, pronoun use, pt confidentiality, support for GS team, & reduce assumptions that problems are related to gender.	need to participate in meaningful occupations. Indiv who have transitioned may need help adjusting to new social roles & entering community in their preferred gender.	system; not all guidelines are applicable.
American Academy of Pediatrics, (2013), *Pediatrics*	Board of Directors, M.D.	Policy statement	Yes	Develop set of organized principles to guide & improve hc of sexual minority children	GD often resolves by adolescence, not always. Higher rates of mental health issues for SM youth of substance abuse, body image distortions, suicidality, social anxiety, PTSD, bullying/abuse & sexual risk taking behaviors. Referral for conversion/reparative therapy is never indicated: not effective & may increase internalized stigma, distress, depression.	Providers should educate themselves on local resources, support development of anti-bullying programs, provide confidential place of support, help child explore gender roles, & assist parents as supportive families can buffer child from neg outcomes. Assess strengths, resources, risks; target interventions to allow child to maximize strengths & minimize/acknowledge risky behaviors.	Majority of rec are based on info collected only in the US, which has been shown to be less progressive.

de Vries, & Cohen-Kettenis, (2012), *JH*	M.D., PhD & PhD	Program overview, AOTA: V	Yes	Describe pioneering role the Netherlands has played in tx of GV youth, "the Dutch protocol."	Dutch protocol involves eval of function: psychosocial, scholastic, cognitive level, other psychopathology, family function. For children under 12yo: tx not aimed at GD but rather on concomitant emotional, behavioral or family problems that may impact GD. Over 12yo: continue psychosocial tx, consider hormonal tx, med interventions.	Take developmental trajectory into account. Do not rec young children make complete social transition before very early stages of puberty due to low rates of GD persistence in youth. Role models of natal sex encouraged, but do not prohibit GV behavior. Encourage middle of road approach; supportive attitude while protecting against neg reactions from others. Consider psychotherapy/counseling aimed at securing pos self image & dealing w/ neg reactions.	Differences exist among American society & Dutch societal norms & acceptance of gender nonconforming youth-may affect generalizability.
Gates, (2011), *The Williams Institute*	PhD, Williams Distinguished Scholar at UCLA School of Law	Census data / Expert opinion, AOTA: V, Pyramid: N/A	Yes	Evaluate size of LGBT population & discuss challenges associated w/ polling LGBT community.	Approx 0.5% of ppl 18-64yo identified as TG, & there are 700,000 TG indiv in the US.	Knowledge of the size of the TG population in the US helps to determine health disparities w/i the LGBT community & assess the prevalence of anti-LGBT discrimination.	The reviewed lit focuses solely on the population of the US.

Coleman et al., (2011), *IJT*	Medical professionals, otherwise unspecified	Standards of practice, AOTA: V, Pyramid: N/A	Yes	Provide clinical guidance for health professionals to assist transsexual, TG & gender nonconforming ppl maximize overall health, psychological well-being & self-fulfillment.	Standards of tx for adults, adolescents & children w/ GD differ by age. The SOC recognize that tx for GD should be per indiv. Emotional & behavioral problems are relatively common. MHPs should not impose a binary view of gender. Families should be supported in managing uncertainty/anxiety and help child develop a pos self-concept.	Educate & advocate for those w/ GD. Provide kids/families w/ info & referral for peer support. Provide supportive psychotherapy to assist clients w/ exploring their GI & alleviate related distress. Assess & treat coexisting MH concerns/refer out. Assess emotional & scholastic functioning, social relationships, eval strengths & weaknesses of family. Support clients in interactions w/ community members & authorities.	Based on research from a North American & Western European perspective.
Burnes et al., (2010), *JLGBTIC*	Board members of Association for Lesbian, Gay, Bisexual & TG Issues in Counseling,	Practice guidelines	Yes	Suggest competencies for use in counseling TG clients, families, groups, or communities. Based on a wellness, resilience & strengths based approach.	Highlight strengths & resilience TG individuals possess despite increased oppression experienced. Counselors are in position to make institutional changes to develop safer settings for TG people; social justice & advocacy are paramount. All indiv holds biases, some unconsciously.	Examine how own biases may influence work. ID challenges that may inhibit client's desired tx (MH, developmental disabilities, cognitive impairment). Create a welcoming clinic environment & use preferred pronouns. Respect individual as a whole, not only GI concerns. Advocate for antidiscrimination policies, assist indiv in self-advocating. Link clients to TG mentors. Be careful not to pathologize GI.	The competencies do not directly refer to svcs solely for youth or family & loved ones of TG individuals. Competencies are not delineated by identity transition (MTF, FTM, genderqueer).

American Psychological Association, (2009)	PhD, Topic experts	Task Force Report	Yes	Develop recc for education, training, further research, collaborations w/ other professional organizations, & practice of working w/ individuals w/ GV.	General needs: education, training, research, allyship, recognition that TG individuals are experts re: issues. Children w/ GID have more peer relationship difficulties & tend to internalize behavior problems/rate self worth & social competence lower, have more neg emotions & higher stress response. Gender nonconforming boys are subject to more neg social responses. As age increases, peer ostracism increases. Difficulties w/ gender constancy/basic concepts re: gender are likely due to GD rather than implicit impairment.	Sex-typed behavior can be assessed thru free play tasks, semi-projective tasks, structured interview schedules, parental reports. Intervention: making a school aware of child's needs, supervised peer support. Children: traditionally, interventions involved eliminating atypical gender behavior. Now, more about modifying child's environment (increasing acceptance). Early behavioral interventions can decrease ostracism but not internal conflict re: gender. Adolescents: GD interferes w/ social adaptation, psychiatric impairment, family relationships, school attendance- attributed to marginalization & stigma. Parents should be involved in tx for best outcomes.	Recs are not specific to field of OT.

Bocktin g, (2009), *SRT*	Associate professor , Program in Human Sexuality	Narrative lit rvw, AOTA: V, Pyramid: N/A	Yes	Highlight the hc of TG indiv (transsexuals, crossdressers, drag queens & kings, bigender, genderqueer, gender variant).	Field is in the midst of a transition from disease-based to identity-based model of TG health.	Social environment & stigma should be the target of of the intervention, not the indiv. Create safe environment in which child can explore their GI. Emphasize pos aspects of being TG by speaking of gender euphoria rather than GD.	The articles discussed do not include info from all disciplines that work w/ indiv w/ GD.
Zucker, et al., (2008), *JSMT*	Employe es of gender clinic	Letter to the editor, AOTA: V, Pyramid: N/A	Yes	To address the impact of media attention on the prevalence rates of GID.	For the children studied, a change in DSM classification of GID spurred an increase in prevalence, but the media did not seem to have an effect. For the adolescents, media portrayals of ppl w/ GID coincided w/ increased prevalence rates. Internet access may also play a role.	If the prevalence of GID is truly increasing, it is even more crucial to establish a model of best practice for this population. All psychiatric training programs should incorporate some exposure to GID in children & adolescents.	Small sample size, population ltd to narrow geographical location, authors may be biased due to professional alliances.
Holman & Goldber g, (2006), *IJT*	Commun ity counselor , education consultan t for TG health program	Expert opinion, AOTA: V, Pyramid: N/A	Yes	General guidelines of care for non-specialists.	Complete care for TG adolescents must be holistic, considering cultural, economic, psychosocial, sexual & spiritual influences. For adolescents who have a defined sense of self, next step is to reconcile discrepancies	A non-specialist can: facilitate peer/family interactions, provide tools to manage & express emotion, practice conflict resolution tactics, provide safe place for disclosure, use pos development approach emphasizing adolescent's competence, confidence &	Recs are limited only to individuals who identify as TG.

					between identity & daily life. Non-med possibilities: peer support/self-help grps, counseling to explore GI & psychosocial pressures, disclosing identity to others, changing gender pronoun/name, episodic cross living, temporary changes to gender expression.	social connectedness, thus promoting resilience & healthy development, feelings of GD or GV, & facilitate "coming out" process. Potential coping mechanisms of GD (cutting, burning, binge eating, substance use) & must be addressed. Use HEEADSS assessment to eval psychosocial concerns.	

Abbreviation List: & = and; AOTA = American Occupational Therapy Association; *ANMJ = Australian Nursing and Midwifery Journal*; approx. = approximately; avail. = available; *CASWJ = Child and Adolescent Social Work Journal*; *CFSW = Child and Family Social Work*; *CPPP = Clinical Practice in Pediatric Psychology*; DSM = Diagnostic and Statistical Manual of Mental Disorders; dx = diagnosis; eval = evaluation; exp(s) = experience(s); FTM = female to male; GD = gender dysphoria; GI = gender identity; GID = gender identity disorder; GP(s) = general practitioner(s); grp(s) = group(s); GS = gender service; GV = gender variance; hc = healthcare; HEEADSSS = Assessment of Home, Education/employment, Eating, Activities, Drugs, Sexuality, Suicide/depression, and Safety; ID = identify; indiv = individual(s); info = information; *IJT = International Journal of Transgenderism*; *JH = Journal of Homosexuality*; *JLGBTIC* = Journal of LGBT Issues in Counseling; *JSMT = Journal of Sex & Marital Therapy*; LGBT = lesbian, gay, bisexual, transgender; LGBTI = lesbian, gay, bisexual, transgender, intersex; lit = literature; ltd = limited; med = medical; MH = mental health; MHP(s) = mental health professional(s); MTF = male to female; N/A = not applicable; NHS = National Health Service; neg = negative; *NEJM = The New England Journal of Medicine*; opp = opposite; OT(s) = occupational therapist(s); pos = positive; ppl = people; pt = patient; PTSD = post-traumatic stress disorder; RCT = randomized control trial; rec = recommend(ations); re: = regarding; rvw = review; SOC = Standards of Care; SM= sexual minority(ies); *SRT = Sexual and Relationship Therapy*; svc(s) = service(s); TG = transgender; thru = through; tx = treatment; UK = United Kingdom; US = United States; w/ = with; w/i = within; yo = year(s) old.

Involvement Plan

Introduction

After discussing the possibilities for knowledge translation regarding the topic, one theme prevailed: Kristin Brubaker's desire to increase awareness around the topic of GD and the potential role for OT. Thus, the researchers decided the most natural choice for the implementation plan would be to provide an in-service presentation. The in-service was conducted at CTI and was attended by three occupational therapists and one OT assistant, who is also the owner. Main highlights and themes from the articles, an introduction to relevant resources in the greater Seattle/Tacoma area, and an open-ended question and answer session were included in the in-service. The researchers also incorporated a brief video and some statistics about GD to make the presentation more engaging. In addition to the in-service, our involvement plan included a fact sheet for the staff, which included key terminology and pertinent practice guidelines from our literature review.

Context

From the beginning, Kristin Brubaker demonstrated interest in and openness to the findings of this study. She expressed that she was excited to delve deeper into this topic because she considers it important as an emerging practice area in the field of OT. Due to her interest and enthusiasm, the researchers felt that she was a vital asset during the knowledge translation process. Furthermore, Kristin Brubaker believed that her colleagues had similar mindsets to her own and would be happy to attend an in-service in order to fortify their current practice with the findings of this study. However, it is important to note that, as of January 1, 2017, the clinic where Kristin Brubaker works is under new ownership. Nonetheless, she felt the new owner would be supportive of the findings of this literature review and in the implementation of an in-service presentation at the facility. Kristin Brubaker discussed the implementation plan with the owner shortly after our meeting and communicated the details of that meeting with us.

The facility is quite small with relatively few employees and clients. The clinic's size provided both benefits and disadvantages to the knowledge translation process. On one hand, the potential benefits included: fewer schedules to coordinate; ability to reach the entire staff during one in-service; less variability in the opinions of the staff; fewer materials needed; and higher probability of large-scale, clinic-wide change. However, the drawbacks included: smaller budget with which to implement practice guidelines, fewer resources provided on-site at the clinic, smaller presentation area, and a limited audience.

As mentioned previously, this population is frequently subjected to widespread discrimination by people who do not acknowledge the gender-variant experience. As such, the public's potential biases may serve as an obstacle to the implementation of the provided recommendations. While these factors have the potential to hinder the knowledge translation process, they are beyond the researchers' control.

Knowledge Translation Activities

In-Service Presentation

The researchers compiled background information, findings, recommendations, and a summary of the research process into a 40-minute presentation for the staff at CTI. Due to the professional makeup of the audience, the majority of the presentation centered on why increasing clinician knowledge of GD is important and how clinicians can better serve these clients. The researchers presented information about the growing number of individuals with GD and the resulting need for gender-affirming care, as well as information regarding rates of discrimination for this population. Specific information about the types and prevalence of discrimination and psychosocial comorbidities that frequently present alongside GD were presented and helped to establish a clear link for the role of OT in supporting this population. The researchers also highlighted the significant positive effects that familial support can have on the psychosocial outcomes of transgender clients, such as decreased rates of suicide, incarceration, homelessness, substance abuse, and sex work.

Clinic-specific suggestions had been previously discussed with Kristin Brubaker, but were also provided to the rest of the CTI staff. These included the modification of intake forms to allow clients to

write in their own genders and/or gender identities and to include preferred names and pronouns on all relevant clinic documents. Another suggestion included the use of gender neutral bathrooms within their clinic space, but this suggestion was irrelevant because their facility had only one bathroom in total. In an effort to highlight the growing presence this population has across all forms of media, the in-service also included a showing of the extended trailer for the recently released documentary, *Gender Revolution: A Journey with Katie Couric*, which provided firsthand perspectives of individuals with GD (National Geographic, 2017). These perspectives emphasized the stigmas and barriers, such as being barred from certain bathrooms or having others frequently misuse preferred names and pronouns, that are so often experienced by individuals with GD living in a traditionally binary society. Upon completion of the presentation, the staff responded positively and expressed their gratitude for the information. They acknowledged the many obstacles surrounding the provision of adequate care for transgender clients. They also agreed that this population deserved more attention from OT practitioners and other health professionals, as these individuals are currently underserved by rehabilitative therapies.

As a whole, the implementation of the in-service presentation went smoothly with a few slight complications. Due to the staff's schedules and needs, the presentation content had to be condensed into a 50-minute window. The presentation also had to be tailored to the setup of the available clinic space so that all attendees could view the presentation. Additionally, as the presentation required the use of unfamiliar equipment, the researchers encountered minor technical difficulties. Despite these unforeseen obstacles, the researchers felt as though the in-service presentation was an overall success and a beneficial first step in the knowledge translation process.

Practitioner Fact Sheet

All staff members at CTI (both those who were present and those who were absent at the time of the presentation) were provided with a double-sided fact sheet outlining the major points of the researchers' findings (see Appendix H for fact sheet). The bulk of the information consisted of general practice recommendations for addressing clients experiencing GD, but also included local resources, national resources, literature recommendations, and definitions. Nine of the most commonly used (and

misused) terms related to this population were outlined and described in accordance with the definitions provided by the Gay and Lesbian Alliance Against Defamation (GLAAD). The most challenging aspects of creating the fact sheet were choosing which information to highlight and determining how to synthesize the most important findings into a digestible amount for a quick reference guide. The researchers chose to include brief descriptions of the information that was addressed in depth during the presentation so that the practitioners could be reminded of the previous evidence they had already been exposed to. As the researchers were departing, the owner of the clinic chose to mount the fact sheet upon the announcement board located in the front lobby of the office. This action, in conjunction with the verbal affirmations made by staff members, led the researchers to believe that the fact sheet was well received.

Table of Met Dates

Task/Product	**Deadline Date**	**Steps with Dates to Achieve Final Outcome**	**Date of Completion**
In-service presentation for all staff members • Approximate length of in-service = 50 minutes	April 7th	1. Confirm in-service date and number of attendees with collaborating clinician by March 3rd. 2. Inquire with University of Puget Sound Technology Services if rental projectors/ screens can be taken off campus by March 3rd. If so, find out details on reservation process. 3. Decide content to be covered by March 3rd. 4. Organize content flow and decide who will cover which parts by March 3rd. 5. Create presentation (e.g., PowerPoint, Prezi, etc.) by March 21st. 6. Select interactive components (e.g., videos, gender implicit bias test, etc.) by March 21st. 7. Develop objectives and exit survey by March 24th. 8. Practice presentation by March 28th. 9. Collect necessary presentation equipment (e.g., fact sheets, projector, etc.) by April 5th. 10. Deliver in-service at collaborating clinician's facility between 11:30am and 12:50pm on April 7th.	1. March 6th 2. March 3rd 3. March 3rd 4. March 3rd 5. April 3rd 6. April 5th 7. March 28th 8. April 4th 9. April 7th 10.April 7th
Fact sheet for practitioners	April 7th	1. Identify key vocabulary terms and practice guidelines to include by March 20th. 2. Formulate a one page draft by March 22nd. 3. Send draft to course mentor for review and feedback by March 22nd. 4. Revise draft and incorporate edits by March 27th. 5. Send final draft to course mentor for approval by March 27th. 6. Print and laminate copies to distribute during in-service by April 5th.	1. March 21st 2. March 21st 3. March 21st 4. April 5th 5. April 4th 6. April 5th
Informational brochure for parents and families	TBD, pending time constraints	TBD	Not completed due to time constraints.

Outcomes and Effectiveness

Prior to the in-service presentation, the attendees were given a pre-presentation survey requesting self-rated responses of their level of knowledge related to the topic of GD and their level of confidence in discussing GD with clients, families, or other practitioners (see Appendix B for pre-presentation survey). Directly following the presentation, the attendees answered the same questions using the same response scale as well as additional questions related to presentation content (see Appendix C for post-presentation survey). Between pre- and post-presentation surveys, the average response value for both level of knowledge and level of confidence increased from 6 to 7.75 and 7.5 to 8, respectively, among the group of attendees (see Appendix D for comparisons of pre- and post-presentation survey responses for each attendee). Additionally, the responses to the new questions included in the post-presentation survey demonstrated that the attendees strongly agreed that the information presented in the in-service was clear, concise, useful, relevant to OT, and feasible to incorporate into practice (see Appendix E for specific results of post-presentation survey). The post-presentation surveys granted the attendees an opportunity to write in responses to two open-ended questions (see Appendix C for specific questions). Three of the attendees did not find any aspects of the presentation confusing, and one attendee responded with a request for clarification during the question and answer portion of the in-service presentation. In response to a survey question, the attendees reported that they enjoyed the provided practitioner fact sheet, the local and national resources, the clear examples of small and immediate changes that could be implemented at their clinic, the methods for spreading awareness of this topic, the specific research findings, the treatment approach recommendations, and the OT-specific suggestions.

Two weeks after the presentation, follow-up surveys were given to every staff member who attended the presentation. This survey was designed to assess the degree to which each attendee implemented the provided practice recommendations and information (see Appendix F for follow-up survey). According to the survey responses, all four attendees had occasionally discussed the topic of GD with their colleagues, and three of the four had occasionally sought additional information regarding GD.

However, the responses to the question regarding incorporating guidelines into treatment fluctuated, as three of the attendees did not have clients with GD on their caseloads (see Appendix G for specific results of follow-up survey). One attendee also hypothesized that a lack of awareness about GD amongst community members might pose a barrier to the full implementation of the researchers' recommendations.

Reflection of Process

Our group was immediately drawn to the unique topic of GD and was especially interested in exploring the role of OT due to the topic's rapidly emerging presence in mainstream culture. However, when we selected the topic, we were unaware of what our year-long process would entail. Our first meeting with Kristin Brubaker was critical in determining the vital components of our project. This meeting included establishing the focused question, addressing why this topic was important, and synthesizing our interpretation of the clinician's needs. We were anxious to begin the first search, but were somewhat disappointed in the initial results as there was a significant lack of OT-specific literature related to GD. Thus, we were apprehensive about presenting our preliminary findings to Kristin Brubaker. Fortunately, after discussing the lack of information with our clinician and mentors, we discovered that the dearth of information was actually an important finding, as this indicates that the field of OT is in dire need of practice recommendations for this population. We were then able to direct the remainder of our search process towards addressing how OT can support individuals experiencing GD.

In addition to the relative absence of OT-specific literature, we quickly realized there was a lack of high level evidence (e.g., randomized controlled trials and systematic reviews) pertaining to this population. We have since realized that this shortage of high level evidence may be due to ethical reasons, as it is unethical to knowingly withhold best practice techniques from specific individuals for the purposes of research. As a result, we had to focus our searches on normative or survey studies, expert opinion pieces, and practice guidelines from other disciplines. Due to the majority of the evidence coming from nontraditional categories, we had to create a separate CAT table to organize these findings as "additional literature". While this may be construed as a limitation, it ultimately led us to the conclusion

that the void in the literature should be supplemented with case studies or similar evidence. We especially hoped to find literature that provided the lived experience perspectives of individuals with GD and their perceptions regarding health care access and overall quality of life; however, we had difficulties finding case studies that fit our inclusion and exclusion criteria.

One of the most difficult aspects of this year-long process was the overall literature search and the organization and presentation of said process. Because we worked with this topic so intimately, we were comfortable with our search process and strategy, but, upon further consideration, we realized certain aspects of it may be confusing for others. As such, presenting our search methods clearly and concisely was both challenging and time intensive. In addition, managing the sheer number of terms related to the topic of GD was daunting. Several of the terms in older literature are now outdated and/or inappropriate, which made incorporation of appropriate terminology critical in presenting our findings. After this year, we are more conscious of the vocabulary we use when discussing GD.

Recommendations

Due to the emerging nature of this topic within the field of OT, this research has the potential to be continued in a variety of ways. For example, there was an overwhelming absence of literature citing OT-specific approaches. Therefore, treatment guidelines for addressing GD in children and adolescents remains an unfulfilled need for practitioners. Further research is needed to determine optimal supports and interventions as well as acknowledge the difficulties that currently impede clients from obtaining the best care possible. In order to accrue this information, the current researchers suggest that future studies should take a more phenomenological approach in pursuance of specific recommendations regarding which traditional practice principles should be modified or avoided altogether while assisting this population. Individuals with GD are vital informants, as only they can provide crucial details regarding techniques they have found to be detrimental or beneficial to their overall psychosocial health. Researchers who conduct follow-up projects may benefit from consultations with the burgeoning gender clinics within the greater Tacoma area (e.g., Seattle Children's Gender Clinic and Mary Bridge Children's Hospital's Pediatric Transgender Program).

In designing research projects that are more conducive to the CAT process, potential research endeavors could expand upon the current focused research question to examine a specific psychosocial outcome experienced by this population (e.g., anxiety, self-harm, depression, suicidal ideation, risky behaviors, bullying, or social isolation) and determine what types of treatment approaches prove to be most effective in improving these outcomes. The current research did not delineate between psychosocial outcomes when reviewing effective treatment strategies. Additionally, future projects could examine the types and prevalence of barriers that prevent meaningful engagement within this population. As presented previously, parent education and involvement have been shown to be integral to a successful treatment approach. Future research could examine what kind of information should be provided to parents, what makes the delivery of parent education effective, and what other needs exist for parents of a child experiencing GD.

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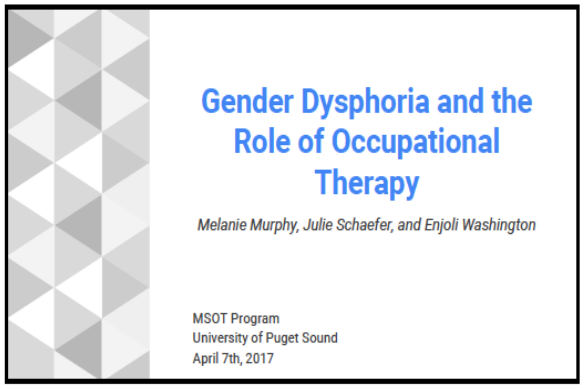
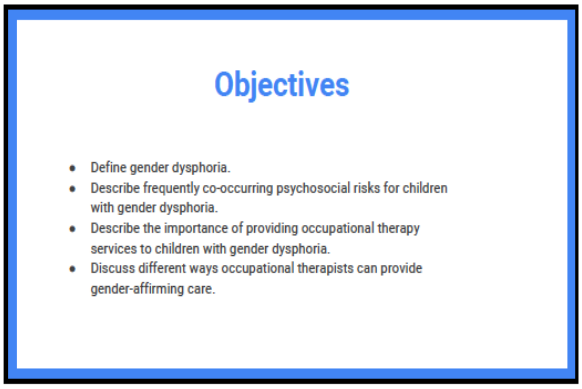
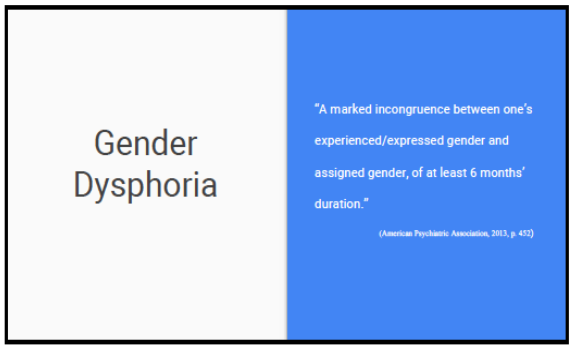
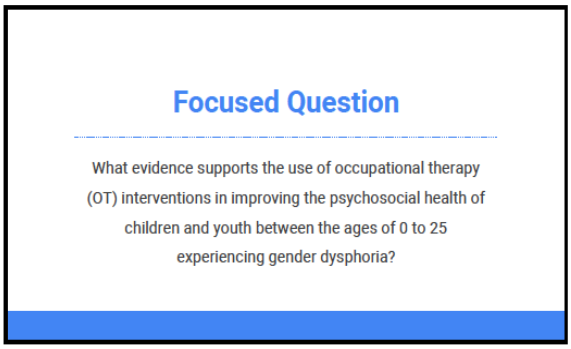
Appendix A

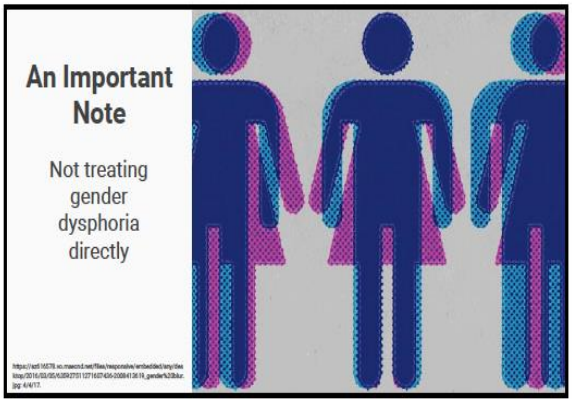
In-Service Presentation

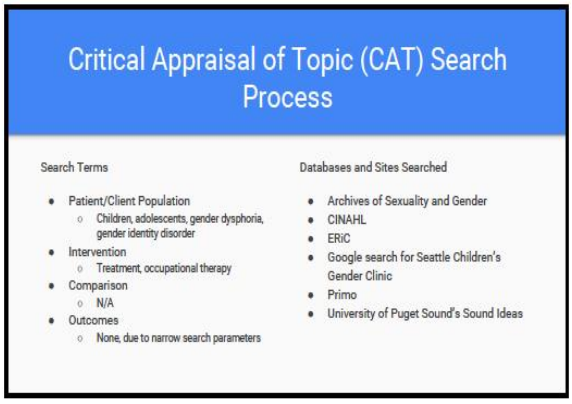












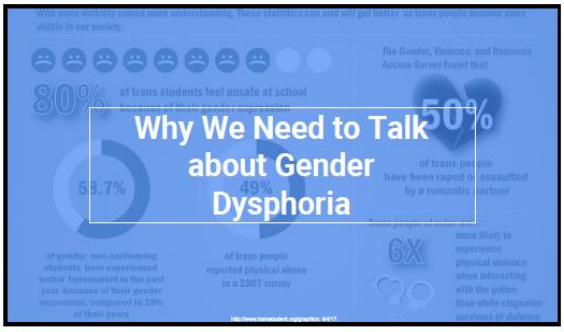
Search Parameters

Inclusion Criteria

- Disciplines: Education, nursing, OT, physical therapy, physiotherapy, psychiatry, psychology, pediatrics (medicine), and social work
- Participants between 0-25 years old
- Interventions/approaches aimed at addressing comorbidities associated with gender dysphoria

Exclusion Criteria

- Published prior to 2000
- Interventions that fell outside the scope of OT practice
- Articles whose focus was not on the participants' gender dysphoria
- Articles previously referenced in literature review or meta-analyses already included in CAT

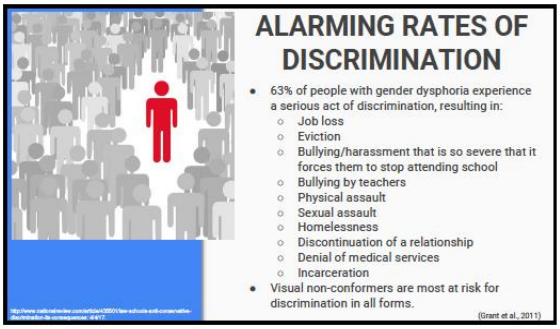


THE POPULATION OF TRANSGENDER ADOLESCENTS IS GROWING RAPIDLY

There was an exceptionally sharp incline in the number of adolescents referred to a gender clinic between 2004 and 2007.

- Theories that may help to explain this increase:
  - "Coming out" at earlier ages
  - Inspired by media portrayals
  - Improved access to information via the Internet

(Zucker et al., 2008)



ALARMING RATES OF DISCRIMINATION

- 63% of people with gender dysphoria experience a serious act of discrimination, resulting in:
  - Job loss
  - Eviction
  - Bullying/harassment that is so severe that it forces them to stop attending school
  - Bullying by teachers
  - Physical assault
  - Sexual assault
  - Homelessness
  - Discontinuation of a relationship
  - Denial of medical services
  - Incarceration
- Visual non-conformers are most at risk for discrimination in all forms.

(Grant et al., 2011)

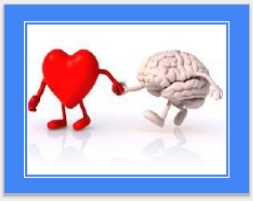
HIGH PREVALENCE OF SOCIAL ISOLATION

- ***Isolation from Families***
  - 57% experienced rejection by their own families
- ***Isolation from Friends***
  - 58% lost at least one close friendship
- ***Isolation from Employers and Coworkers***
  - 45% felt that coworkers utilized incorrect pronouns repeatedly and on purpose
- ***Isolation from Public Life***
  - 22% denied access to restrooms that matched their gender identity

(Grant et al., 2011)

STAGGERING INCIDENCES OF PSYCHOSOCIAL COMORBIDITIES

- Children with gender dysphoria have a serious risk of developing one or more co-occurring disorders (Wallien et al., 2007)
- These comorbidities often include:
  - Anxiety disorders (Wallien et al., 2007)
  - Depression (Holt et al., 2016)
  - Suicidal ideations (Grant et al., 2011)
  - Self-harm (Holt et al, 2016)
  - Drug addiction (Grant et al., 2011)
  - Alcohol addiction (Grant et al., 2011)



Familial Acceptance as an Insulating Factor

RISK FACTOR	REJECTION BY FAMILIES	ACCEPTANCE BY FAMILIES
Suicide	51%	32%
Incarceration	19%	11%
Homelessness	26%	9%
Substance Abuse	32%	19%
Sex Work	13%	7%

(Grant et al, 2011)

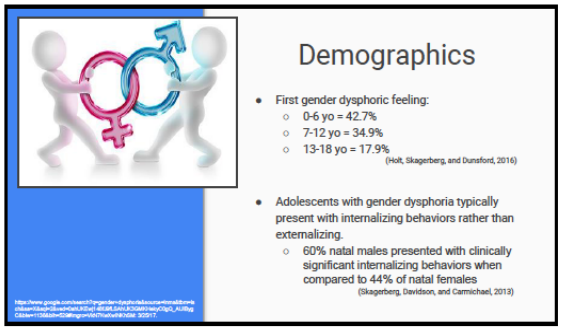
THESE ISSUES ARE FURTHER COMPOUNDED FOR PEOPLE OF COLOR

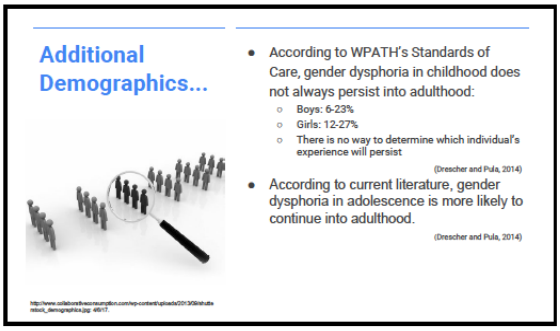
People of color experience even more significant levels of discrimination in the following areas of life:

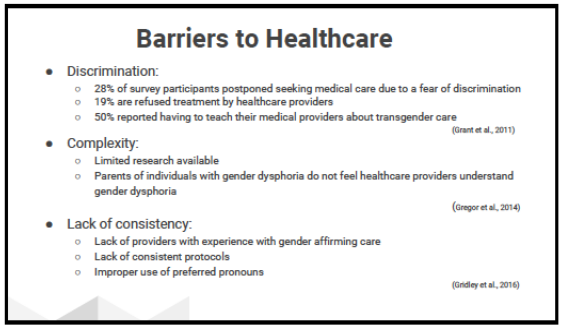
- education
- employment
- health
- family life
- housing
- public accommodations
- identification documents
- police and incarceration

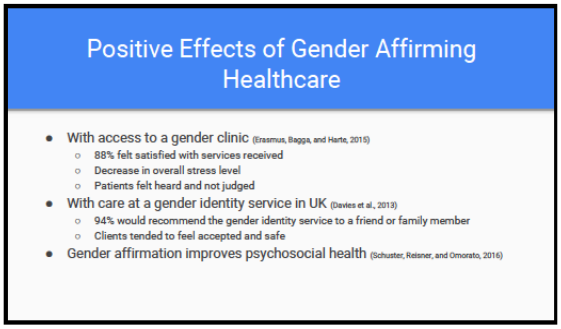
(Grant et al, 2011)

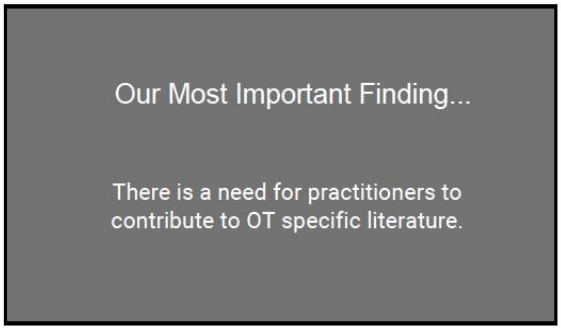

Findings


Demographics
First gender dysphoric feeling:
0-6 yo = 42.7%
7-12 yo = 34.9%
13-18 yo = 17.9%
(Holt, Skagerberg, and Dunsford, 2016)
Adolescents with gender dysphoria typically present with internalizing behaviors rather than externalizing.
60% natal males presented with clinically significant internalizing behaviors when compared to 44% of natal females
(Skagerberg, Davidson, and Carmichael, 2013)


Additional Demographics...
According to WPATH's Standards of Care, gender dysphoria in childhood does not always persist into adulthood:
Boys: 6-23%
Girls: 12-27%
There is no way to determine which individual's experience will persist
(Drescher and Pula, 2014)
According to current literature, gender dysphoria in adolescence is more likely to continue into adulthood.
(Drescher and Pula, 2014)


Barriers to Healthcare
Discrimination:
28% of survey participants postponed seeking medical care due to a fear of discrimination
19% are refused treatment by healthcare providers
50% reported having to teach their medical providers about transgender care
(Grant et al., 2011)
Complexity:
Limited research available
Parents of individuals with gender dysphoria do not feel healthcare providers understand gender dysphoria
(Gregor et al., 2014)
Lack of consistency:
Lack of providers with experience with gender affirming care
Lack of consistent protocols
Improper use of preferred pronouns
(Gridley et al., 2016)


Positive Effects of Gender Affirming Healthcare
With access to a gender clinic (Erasmus, Bagga, and Harte, 2015)
88% felt satisfied with services received
Decrease in overall stress level
Patients felt heard and not judged
With care at a gender identity service in UK (Davies et al., 2013)
94% would recommend the gender identity service to a friend or family member
Clients tended to feel accepted and safe
Gender affirmation improves psychosocial health (Schuster, Reisner, and Omorato, 2016)


Our Most Important Finding...
There is a need for practitioners to contribute to OT specific literature.


Role of Occupational Therapy

The First Step to Gender Affirming Care

- Check biases and preconceived notions related to this population
- The more knowledgeable a provider is, the better they can serve their clients (Ettner, White, Brown, and Shah, 2006)

Currently, There Are No OT Specific Practice Guidelines...

- However, there is an enormous amount of evidence supporting the role clinicians may provide for this population.
  - Clinicians can actively support client health by addressing the risk of verbal and physical assault, helping with emotional challenges related to disclosing gender identity, discussing medical options for gender affirmation, and supporting both clients and families (Schuster, Reisner, & Onorato, 2016)

Practice Recommendations

- Client-centered care
- Validation of concerns
- Provide safe and supportive environment in which children can disclose their feelings
- Advocate

STRENGTHS-BASED APPROACH

Maximizing:

Strengths

Resources

Competencies

Social connectedness

(Holman & Goldberg, 2006)

Best Practice for Youth Remains Controversial

Remember: it will vary client by client!

- Consider developmental trajectory
- "Cautious approach"
- Effects of full social transition: no empirical evidence supporting either way
- Present all information to family, allow them to have final decision

(Drescher and Pula, 2014)

Treatment Approach Based On Age

- **Children under 12**
  - Treatment should not target gender dysphoria via medication interventions
  - Focus on emotional, behavioral, or familial problems
- **Children over 12**
  - Continue existing psychosocial treatments
  - Consideration and discussion of hormonal/medical interventions

(de Vries, & Cohen-Kettenis, 2012)

Youth & Gender Dysphoria

- Do not deny the existence of gender dysphoria
- Encourage exploration of gender identity while protecting against negative reactions from others

OT Specific Suggestions

- In the event of social transition:
  - Assist child in adjusting to new social roles
  - Prevent loss of engagement in meaningful occupations

OT Specific Suggestions

- Assess client's' safety in school and other environments
- Rehearse scripts to counter bullying or questions
- Facilitate "coming out" process with involved parties (teachers, classmates, community members)
- Take into account the complex presentation of gender dysphoria–it should not be regarded as a singular issue.

POTENTIAL AREAS OF PROGRAM DEVELOPMENT

- Increase general awareness of gender variant experiences
- Encourage peer support
- Promote anti-bullying campaigns

Clinic Specific Suggestions

- Modifying intake forms
  - Ask about gender identity on registration forms
    - Provide a write in option
- Inquiring about preferred names and pronouns
  - Document preferences
- Maintaining an awareness of local resources

Through collaboration, occupational therapists can help clients experiencing gender dysphoria move forward to live an independent, healthy, safe, functional, and fulfilling life that matches their experienced gender.

Collaborating Clinician: Kristin Brubaker, MOT, OTR/L

Audience: Center for Therapeutic Intervention

Course Mentor: George Tomlin, PhD, OTR/L, FOATA

Faculty Chair: Kirsten Wilbur EdD, OTR/L

Science Liaison Librarian: Eli Gandour-Rood

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Appendix B

Pre-Presentation Survey

1) I feel knowledgeable about the topic of gender dysphoria.

Least Knowledgeable *Neutral* *Most Knowledgeable*

1 2 3 4 5 6 7 8 9 10

2) I feel confident discussing gender dysphoria with clients, families, or other practitioners.

Least Confident *Neutral* *Most Confident*

1 2 3 4 5 6 7 8 9 10

Appendix C

Post-Presentation Survey

Please rate the following:

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Does Not Apply**
I feel this presentation was clear and concise.						
I found this topic interesting and relevant to OT practice.						
I think this information was useful.						
I can envision myself incorporating this information into my practice.						

1) I feel knowledgeable about the topic of gender dysphoria.

Least Knowledgeable *Neutral* *Most Knowledgeable*

1 2 3 4 5 6 7 8 9 10

2) I feel confident discussing gender dysphoria with clients, families, or other practitioners.

Least Confident *Neutral* *Most Confident*

1 2 3 4 5 6 7 8 9 10

3) What did you most enjoy about this presentation?

_____

_____

4) What, if any, aspects of the presentation were confusing?

_____

_____

_____

Appendix D

Comparison of Pre- and Post-Presentation Survey Responses

Participant	**Level of Knowledge About Topic (average among attendees)**		**Level of Confidence In Discussing Topic (average among attendees)**	
	PRE	**POST**	**PRE**	**POST**
1	3	5	8	8
2	8	9	8	8
3	7	9	8	9
4	6	8	6	7
Average	6	7.75	7.5	8

Appendix E

Results: Post-Presentation Survey

	Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	**Does Not Apply**
I feel this presentation was clear and concise.					4	
I found this topic interesting and relevant to OT practice.					4	
I think this information was useful.					4	
I can envision myself incorporating this information into my practice.				1	3	

Note. The number values indicate the number of attendees that chose each response.

Appendix F

Follow-Up Survey

Please rate the following:

	Frequently	**Occasionally**	**Never**	**Does Not Apply**
I have discussed the topic of gender dysphoria with my colleagues since the in-service presentation.				
I have sought additional information regarding gender dysphoria since the in-service presentation.				
I have incorporated one or more of the recommended practice guidelines into my treatment sessions.				

1) **If you selected 'frequently' or 'occasionally' for incorporation of practice guidelines, please specify which guidelines you have incorporated. (Check all that apply.)**
   - ☐ Modifying intake forms
   - ☐ Inquiring about and documenting preferred names and pronouns
   - ☐ Recommended local resources and/or researched additional resources

2) **Please provide any additional explanations for the previously answered questions.**

_____

_____

_____

3) **Have you encountered any supports or barriers to the implementation of the recommendations we provided? Please explain.**

_____

_____

_____

Appendix G

Results: Follow-Up Survey

	Frequently	**Occasionally**	**Never**	**Does Not Apply**
I have discussed the topic of gender dysphoria with my colleagues since the in-service presentation.		4		1*
I have sought additional information regarding gender dysphoria since the in-service presentation.		3	1	1*
I have incorporated one or more of the recommended practice guidelines into my treatment sessions.	1	1	1	2*

Note. The number values indicate the number of attendees that chose each response.

*One respondent selected two responses for each question. Thus, the table above reflects five responses, even though there were only four respondents.

Appendix H

Fact Sheet for Practitioners

GENDER DYSPHORIA & THE ROLE OF OCCUPATIONAL THERAPY

LOCAL RESOURCES

- GENDER ALLIANCE OF THE SOUTH SOUND, www.southsoundgender.com
- OASIS & RAINBOW CENTER, www.oasisyouthcenter.org/
- SEATTLE CHILDREN'S GENDER CLINIC, www.seattlechildrens.org/clinics-programs/gender-clinic/

NATIONAL RESOURCES

- GLAAD: Gay and Lesbian Alliance Against Defamation, www.glaad.org/transgender
- PFLAG: Parents, Families and Friends of Lesbians and Gays, www.pflag.org/transgender
- NATIONAL LGBT HEALTH EDUCATION CENTER, www.lgbthaltheducation.org/

LITERATURE

- American Psychological Association, Task Force on Gender Identity and Gender Variance. (2009). Report of the task force on gender identity and gender variance. Washington, DC: Author.
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Practice Recommendations

⇒ Remain true to OT ideals such as client-centered care, validating clients' concerns, and advocating for clients.

⇒ Provide a supportive and safe environment in which children can disclose their feelings without fear of repercussion.

⇒ Providers should be aware of and reflect upon their preconceived notions and biases related to this population.

⇒ Consider developmental trajectory; it is not always recommended that young children make the complete social transition to a new gender before the early stages of puberty due to the low rates of gender dysphoria (GD) persistence into adolescence.

⇒ Do not deny the existence of GD; instead, work in a collaborative way that facilitates clients' exploration of gender identity rather than invalidates their experiences.

⇒ Use an individualized, strengths-based approach throughout treatment.

⇒ Assist the child in adjusting to new social roles while re-entering the community in a new gender.

⇒ Prevent loss of engagement in meaningful occupations while transitioning from one gender to another.

⇒ Assess client safety at school, rehearse scripts to counter questions or bullying, and/or facilitate the coming out or transitioning process with involved parties (e.g., teachers, classmates, community members).

⇒ Inquire about and use preferred pronouns.

⇒ Take into account the complex presentation of associated sequelae that often accompany the experience of GD. Many factors influence the trajectory of GD, and it should not be regarded as a singular issue.

⇒ Be aware that children with GD are more likely than their peers without GD to experience internalizing behaviors, such as depression and anxiety.

⇒ Be prepared to incorporate additional treatment methods to address coexisting mental health concerns, and provide information and recommendations for peer and family support groups.

⇒ Areas of potential program development: advocating for general awareness of the gender-variant experience, encouraging peer support, and promoting anti-bullying campaign.

(Image from: http://manhattanpsychologygroup.com/understanding-gender-dysphoria-children-adolescents/)

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KEY VOCABULARY TERMS [1]

Cisgender: "A term used by some to describe people who are not transgender. "Cis-" is a Latin prefix meaning "on the same side as.""

Gender dysphoria: A discrepancy between the sex one was assigned at birth and how they experience their own gender. "In 2013, the American Psychiatric Association released the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) which replaced the outdated entry "Gender Identity Disorder" with Gender Dysphoria, and changed the criteria for diagnosis. Some transgender advocates believe the inclusion of Gender Dysphoria in the DSM is necessary in order to advocate for health insurance that covers the medically necessary treatment recommended for transgender people."

Gender expression: "External manifestations of gender, expressed through a person's name, pronouns, clothing, haircut, behavior, voice, and/or body characteristics. Society identifies these cues as masculine and feminine, although what is considered masculine or feminine changes over time and varies by culture. Typically, transgender people seek to align their gender expression with their gender identity, rather than the sex they were assigned at birth."

Gender identity: "A person's internal, deeply held sense of their gender. For transgender people, their own internal gender identity does not match the sex they were assigned at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression, gender identity is not visible to others."

Gender non-conforming: "A term used to describe some people whose gender expression is different from conventional expectations of masculinity and femininity. Please note that not all gender non-conforming people identify as transgender; nor are all transgender people gender non-conforming. Many transgender men and women have gender expressions that are conventionally masculine or feminine. The term is not a synonym for transgender or transsexual and should only be used if someone self-identifies as gender non-conforming."

Non-binary and/or genderqueer: "Terms used by some people who experience their gender identity and/or gender expression as falling outside the categories of man and woman. The term is not a synonym for transgender or transsexual and should only be used if someone self-identifies as non-binary and/or genderqueer."

Trans: "Used as shorthand to mean transgender or transsexual - or sometimes to be inclusive of a wide variety of identities under the transgender umbrella. Because its meaning is not precise or widely understood, be careful when using it with audiences who may not understand what it means."

Transgender (adj.): "An umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. People under the transgender umbrella may describe themselves using one or more of a wide variety of terms - including transgender."

Transsexual (adj.): "An older term that originated in the medical and psychological communities. Still preferred by some people who have permanently changed - or seek to change - their bodies through medical interventions, including but not limited to hormones and/or surgeries. Unlike transgender, transsexual is not an umbrella term."

[1] Gay and Lesbian Alliance Against Defamation. (n.d.). Media reference guide: Glossary of terms—transgender. Retrieved from http://www.glaad.org/reference/transgender.

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